General Information

First Name:	Last Name:	Suffix: (Ph.D., M.S., B.S., etc.)
Mailing Address:		
City:	State:	ZIP:
Primary Phone Number:	Cell Phone Number:	
Email Address:		
Primary Facility of Employment:		
Facility Address: (Street, City, State, ZIP):		
(If employed at multiple facilities, please complete Appendix A to include each facility)		

Categories of Recognition

(Check applicable Pathway)

☐	Path One: Nationally-Recognized Certifying Body
☐	Path Two: Degree Plus Training and Experience (Masters/Ph.D. Degree)
☐	Path Three: Alternative Standard

Path One: Nationally-Recognized Certifying Body

Board Certification	**Area of Certification**
☐ American Board of Radiology (ABR)	☐ Radiology
☐ American Osteopathic Board of Radiology (AOBR)	☐ Therapeutic Radiology
☐ Fellow of the Faculty of Radiology	☐ Radiation Oncology
☐ Fellow of the Royal College of Radiology	☐ Radiotherapy
☐ Canadian Royal College of Physicians and Surgeons	☐ Other (Specify):
☐ Other (Specify)	

ATTACH COPY OF BOARD CERTIFICATION

Path Two: Degree Plus Training and Experience

Description of Training	Location of Training	Clock Hours	Dates of Training
Radiation physics and instrumentation			
Radiation protection			
Mathematics pertaining to the use and measurement of ionizing radiation			
Radiation biology			
Total Clock Hours (Must be at least 200 hours)			

Description of Supervised Work Experience	Location of Work Experience	Clock Hours	Dates of Work Experience
Review of the full calibration measurements and periodic quality assurance checks			
Use of administrative controls to prevent misadministrations (medical events)			
Evaluation of prepared treatment plans and calculation of treatment times and patient treatment settings			
Implementing emergency procedures to be followed in event of the abnormal operation of an external beam radiation therapy unit or console			
Checking and using survey meters			
Total Clock Hours (Must be at least 500 hours)			
Supervising Authorized User Name:			

Description of Supervised Clinical Experience	Location of Clinical Experience	Years of Clinical Experience	Dates of Clinical Experience
One (1) Year approved residency program			
Examining individuals and reviewing their case histories to determine their suitability for external beam radiation therapy treatment and any limitations/contraindications			
Selecting proper dose and how it is to be administered			
Calculating external beam radiation therapy doses and collaborating with the Authorized User in the review of patient progress and consideration of need to modify originally prescribed doses and/or treatment plans as warranted by patients' reaction to radiation			
Post-administration follow-up and review of case histories			
Total Years of Clinical Experience (Must be at least one (1) year residency PLUS two (2) years additional experience)			
Supervising Authorized User Name:			

Path Three: Alternative Standard

Submit documentation of the training and experience of the prospective Authorized User physician for review on a case-by-case basis.

Preceptor Attestation:

Note: This part must be completed by the individual's preceptor. The preceptor does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each.

I attest that _____has satisfactorily completed a 1-year residency in radiation therapy approved by the Residency Review Committee for Radiology of the Accreditation Council for Graduate Medical Education or the Committee on Postdoctoral Training of the American Osteopathic Association and an additional 2 years of full-time work experience; has training and experience that includes examining individuals and reviewing their case histories to determine their suitability for external beam radiation therapy treatment, and any limitations/contraindication; selecting proper dose and how it is to be administered; calculating the external beam radiation therapy doses and collaborating with the authorized user in the review of patients' progress and consideration of the need to modify originally prescribed doses and/or treatment plans as warranted by patients' reaction to radiation; and post-administration follow-up and review of case histories.

Complete the following for preceptor attestation and signature:

As preceptor, I meet the common qualifications of recognition for the types of use for which the above-named individual seeks authorization.

_____ _____
Name of Preceptor Signature

_____ _____
Phone Number Date

_____
Kansas Registration Number

Signature of Applicant for Authorized User

I certify that the information provided on this application is true and accurate, and I give my permission to the Department officials to verify information as needed.

If my contact information changes, I agree to notify KDHE, Bureau of Community Health Systems, Radiation Control Program, 1000 SW Jackson, Suite 330, Topeka, KS 66612-1365 by phone at 785-296-1560, email at kdhe.xray@ks.gov or fax at 785-559-4251.

_____ _____

Signature of Applicant Date

Submit this completed form and training certificates to:
Kansas Department of Health and Environment
Bureau of Community Health Systems
Radiation Control Program
1000 SW Jackson, Suite 330
Topeka, KS 66612-1365
Phone: 785-296-1560, Fax: 785-559-4251
Email Address: kdhe.xray@ks.gov

KDHE - RADIATION CONTROL PROGRAM USE ONLY
Reviewed By:
Date Approved:

Approved ☐	**Not Approved** ☐

Comments from Reviewer:

Appendix A – Facility List

Facility of Employment:
Facility Address: (Street, City, State, ZIP)

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Facility Address: (Street, City, State, ZIP)

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